



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
5501 S MCCOLL RD
MCALLEN TX 78539

Respondent Name

Edinburg Consolidated ISD

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-12-2585-01

MFDR Date Received

April 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Labor Code 134.403"

Amount in Dispute: \$638.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The diagnostic test was not pre-authorized in accordance with Rule 134.600 (8)(A), as such the bill was denied in its entirety. The claim was processed properly and the Carrier maintains that the provider is not due reimbursement."

Response Submitted by: Thornton Biechlin Segrato Reynolds & Guerra, L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 25, 2011	Outpatient Hospital Services	\$638.42	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 4, 2011

- T197 – Payment denied/reduced for absence of, or exceeded, pre-certification and/or authorization.

Explanation of benefits dated March 9, 2012

- T153 – No additional reimbursement allowed after review of appeal/reconsideration.

- T197 – Payment denied/reduced for absence of, or exceeded, pre-certification and/or authorization.

Issues

1. Did the respondent support the insurance carrier's reason for denying procedure code 73721?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed surgical services billed under procedure code 73721 with reason code T197 – Payment denied/reduced for absence of, or exceeded, pre-certification and/or authorization." Review of submitted documentation did not find evidence to support that this service had been preauthorized. The insurance carrier's denial reason is supported.
2. Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services."
3. The disputed service was not pre-authorized, no reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	June 5, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service* demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.